		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTOR PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041707

Facility Name: Bement Health Care Center

Address: 601 North Morgan Street (Number) Bement (City) 61813 (Zip Code)

County: Piatt

Telephone Number: (217) 678-2191 **Fax #** (217) 678-7521

IDPA ID Number: 371346306001

Date of Initial License for Current Owners: 02/02/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to th State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance wit applicable instructions. Declaration of preparer (other than provide is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any informatio in this cost report may be punishable by fine and/or imprisonmen

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,620	4,918	1,408	20,946	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,620	4,918	1,408	20,946	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.64%

D. How many bed-hold days during this year were paid by Public Aid?
64 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 02/02/96

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 02/02/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 8 and days of care provided 1,375

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basi

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	97,862	9,062	3,582	110,506		110,506	19	110,525			1
2	Food Purchase		93,681		93,681		93,681	(2,280)	91,401			2
3	Housekeeping	61,220	11,461		72,681		72,681		72,681			3
4	Laundry	34,005	12,523	152	46,680		46,680		46,680			4
5	Heat and Other Utilities			52,130	52,130		52,130	344	52,474			5
6	Maintenance	31,546	34,266	3,614	69,426		69,426	421	69,847			6
7	Other (specify):*											7
8	**TOTAL General Services**	224,633	160,993	59,478	445,104		445,104	(1,496)	443,608			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	562,461	42,437	2,342	607,240		607,240		607,240			10
10a	Therapy		232	89,915	90,147		90,147		90,147			10a
11	Activities	16,965	392	1,350	18,707		18,707		18,707			11
12	Social Services	21,870	354	1,100	23,324		23,324	4	23,328			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	601,296	43,415	103,707	748,418		748,418	4	748,422			16
	C. General Administration											
17	Administrative	114,339		18,228	132,567		132,567	(18,228)	114,339			17
18	Directors Fees											18
19	Professional Services			20,689	20,689		20,689	2,891	23,580			19
20	Dues, Fees, Subscriptions & Promotions			5,629	5,629		5,629	168	5,797			20
21	Clerical & General Office Expense	33,193	6,517	12,225	51,935		51,935	7,954	59,889			21
22	Employee Benefits & Payroll Taxe			129,414	129,414		129,414	10,692	140,106			22
23	Inservice Training & Educatior			1,292	1,292		1,292	38	1,330			23
24	Travel and Seminar			16,997	16,997		16,997	1,120	18,117			24
25	Other Admin. Staff Transportatior			3,250	3,250		3,250	1,249	4,499			25
26	Insurance-Prop.Liab.Malpractice			37,603	37,603		37,603	1,549	39,152			26
27	Other (specify):*											27
28	**TOTAL General Administration**	147,532	6,517	245,327	399,376		399,376	7,433	406,809			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	973,461	210,925	408,512	1,592,898		1,592,898	5,941	1,598,839			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $100(SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassificatior

Facility Name & ID Number Bement Health Care Center #0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger										
	Capital Expense	Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			52,390	52,390		52,390	7,864	60,254			30
31	Amortization of Pre-Op. & Org			170	170		170		170			31
32	Interest			119,733	119,733		119,733	823	120,556			32
33	Real Estate Taxes			29,381	29,381		29,381		29,381			33
34	Rent-Facility & Grounds							2,166	2,166			34
35	Rent-Equipment & Vehicles			961	961		961	1,508	2,469			35
36	Other (specify):*											36
37	**TOTAL Ownership**			202,635	202,635		202,635	12,361	214,996			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Centers		18,190	2,146	20,336		20,336	(2,146)	18,190			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):* Nonallowable costs			9,285	9,285		9,285	(9,285)				43
44	**TOTAL Special Cost Centers**		18,190	44,281	62,471		62,471	(11,431)	51,040			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	973,461	229,115	655,428	1,858,004		1,858,004	6,871	1,864,875			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

**See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,082)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,186)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,753	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,855)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona	(1,732)	43		25
26	Income Taxes and Illinois Persona Property Replacement Tax	(276)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(5,039)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (11,417)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organizatior Costs (Schedule VII)	18,288		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 18,288		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 6,871		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center
Provider # 0041707
12/31/2001

Schedule 5A

VI. Adjustment Detail
Non-Allowable Expenses
Line 29 - Other

Description	Amount	Schedule V Reference
Offset Miscellaneous Income	(359)	21
Offset Vending Income	(1,198)	2
Disallow PAC dues	(100)	20
Disallow Special Events	(1,236)	43
Disallow Radiology	(1,073)	39
Disallow Laboratory	(1,073)	39
Total	(5,039)	

See Accountants' Compilation Report

Bement Health Care Center

ID# 0041707

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bement Health Care Center # 0041707 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	19	0	0	0	0	0	0	0	0	0	19	1
2	Food Purchase	(1,082)	0	0	0	0	0	0	0	0	0	0	(1,082)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	344	0	0	0	0	0	0	0	0	0	344	5
6	Maintenance	0	421	0	0	0	0	0	0	0	0	0	421	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,082)	784	0	0	0	0	0	0	0	0	0	(298)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	4	0	0	0	0	0	0	0	0	0	4	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	4	0	0	0	0	0	0	0	0	0	4	16
	C. General Administration													
17	Administrative	0	(18,228)	0	0	0	0	0	0	0	0	0	(18,228)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,891	0	0	0	0	0	0	0	0	0	2,891	19
20	Fees, Subscriptions & Promotions	0	268	0	0	0	0	0	0	0	0	0	268	20
21	Clerical & General Office Expenses	0	8,313	0	0	0	0	0	0	0	0	0	8,313	21
22	Employee Benefits & Payroll Taxes	0	10,692	0	0	0	0	0	0	0	0	0	10,692	22
23	Inservice Training & Education	0	38	0	0	0	0	0	0	0	0	0	38	23
24	Travel and Seminar	0	1,120	0	0	0	0	0	0	0	0	0	1,120	24
25	Other Admin. Staff Transportation	0	1,249	0	0	0	0	0	0	0	0	0	1,249	25
26	Insurance-Prop.Liab.Malpractice	0	1,549	0	0	0	0	0	0	0	0	0	1,549	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	7,892	0	0	0	0	0	0	0	0	0	7,892	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,082)	8,680	0	0	0	0	0	0	0	0	0	7,598	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Bement Health Care Center** **#** **0041707** **Report Period Beginning:** **01/01/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,753	0	5,111	0	0	0	0	0	0	0	0	7,864	30
31	Amortization of Pre-Op. & Org	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	823	0	0	0	0	0	0	0	0	823	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,166	0	0	0	0	0	0	0	0	2,166	34
35	Rent-Equipment & Vehicles	0	0	1,508	0	0	0	0	0	0	0	0	1,508	35
36	Other (specify):[4]	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,753	0	9,608	0	0	0	0	0	0	0	0	12,361	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportatior	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):[4]	(8,049)	0	0	0	0	0	0	0	0	0	0	(8,049)	43
44	**TOTAL Special Cost Centers**	(8,049)	0	0	0	0	0	0	0	0	0	0	(8,049)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(6,378)	8,680	9,608	0	0	0	0	0	0	0	0	11,910	45

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	60.00%	See Attached Schedule		See Attached Schedule		
Mark Petersen	40.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Companies	0.00%	$ 19	$ 19	1
2	V	5	Utilities		Petersen Health Care Companies	0.00%	344	344	2
3	V	6	Maintenance Supplies		Petersen Health Care Companies	0.00%	421	421	3
4	V	12	Social Services		Petersen Health Care Companies	0.00%	4	4	4
5	V	17	Adminstrative	18,228	Petersen Health Care Companies	0.00%		(18,228)	5
6	V	19	Professional Services		Petersen Health Care Companies	0.00%	2,891	2,891	6
7	V	20	Fees Subscriptions & Promotions		Petersen Health Care Companies	0.00%	268	268	7
8	V	21	Clerical & General Office Exp		Petersen Health Care Companies	0.00%	8,313	8,313	8
9	V	22	Employee Benefits		Petersen Health Care Companies	0.00%	10,692	10,692	9
10	V	23	Inservices Training & Education		Petersen Health Care Companies	0.00%	38	38	10
11	V	24	Travel & Seminar		Petersen Health Care Companies	0.00%	1,120	1,120	11
12	V	25	Other Admin. Staff Transport		Petersen Health Care Companies	0.00%	1,249	1,249	12
13	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care Companies	0.00%	1,549	1,549	13
14	Total			$ 18,228			$ 26,908	$ * 8,680	14

* Total must agree with the amount recorded on line 34 of Schedule VI

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Petersen Health Care Companies	0.00%	$ 5,111	$ 5,111	15
16	V	32	Interest		Petersen Health Care Companies	0.00%	823	823	16
17	V	34	Rent-Facility & Grounds		Petersen Health Care Companies	0.00%	2,166	2,166	17
18	V	35	Rent-Equipment & Vehicles		Petersen Health Care Companies	0.00%	1,508	1,508	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 9,608	$ * 9,608	39

* Total must agree with the amount recorded on line 34 of Schedule VI

Bement Health Care Center
Provider # 0041707
12/31/2001

VII Related Parties-Page 6

Related Nursing Home	**City**
Robings Manor Nursing Home	Brighton, IL
Countryview Terrace	Louisville, IL
Sunset Manor Nursing Home	Canton, IL
Kewanee Care Home	Kewanee, IL
Arcola Health Care Center	Arcola, IL
Eastview Terrace	Sullivan, IL
Havana Health Care Center	Havana, IL
Prairie City Health Care Center	Prairie City, IL

Out of State Nursing Home

Friendly Village	Rhinelander, WI
Horizons Unlimited	Rhinelander, WI
Taylor Park	Rhinelander, WI
Passport	Rhinelander, WI
Meadow Lawn Nursing Center	Davenport, IA
Cumberland Heights-Tomahawk	Tomahawk, WI
Maple Park	Rhinelander, WI
Opportunities Unlimited (Workshop setup, no beds)	

Other Related Business Entities

Petersen Health Care Companies	Peoria, IL Management/ Bookkeeping
Petersen Property	Canton, IL Building-Sunset Manor

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	James Petersen	President	Administrative	60.00	512,937	5	12.50	Salary	$ 53,064	L17, C1	1
2	Mark Petersen	Secretary	Administrative	40.00	222,530	5	12.50	Salary	23,021	L17, C1	2
3	Todd Petersen	Administrative	Administrative	0.00	64,647	5	12.50	Salary	6,688	L21, C1	3
4											4
5											5
6											6
7											7
8					See attached schedule 7A						8
9											9
10											10
11											11
12											12
13								TOTAL	$ 82,773		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Kewanee Care Center
Provider # 00026518
12/31/2001

Schedule 7A

VII. Related Parties (continued)
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors
Compensation Received From Other Nursing Homes

Name	Kewanee Care Center	Country View Terrace	Eastview Terrace	Arcola Health Care	Meadow Lawn Nursing	Robings Manor	Sunset Manor	Havana Care Center	Prairie City	Total	Bement Health Care	Grand Total
James Petersen	68,695	14,795	52,568	88,261	58,818	60,034	91,851	59,421	18,494	512,937	53,064	566,001
Mark Petersen	29,802	6,419	22,806	38,291	25,517	26,045	39,848	25,779	8,023	222,530	23,021	245,551
Todd Petersen	8,658	1,865	6,625	11,124	7,413	7,566	11,576	7,489	2,331	64,647	6,688	71,335
Total Compensation Received From Other Nursing Homes	107,155	23,079	81,999	137,676	91,748	93,645	143,275	92,689	28,848	800,114	82,773	882,887

See Accountants' Compilation Repor

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions. YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheet

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, Illinois 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	223,416	8	$ 200	$	20,946	$ 19	1
2	5	Utilities	Patient Days	223,416	8	3,666		20,946	344	2
3	6	Maintenance Supplies	Patient Days	223,416	8	4,490		20,946	421	3
4	12	Social Services	Patient Days	223,416	8	40		20,946	4	4
5	19	Professional Services	Patient Days	223,416	8	30,834		20,946	2,891	5
6	20	Fees, Subscriptions & Promotions	Patient Days	223,416	8	2,859		20,946	268	6
7	21	Clerical & General Office Expense	Patient Days	223,416	8	88,667		20,946	8,313	7
8	22	Employee Benefits	Patient Days	223,416	8	114,040		20,946	10,692	8
9	23	Inservices Training & Education	Patient Days	223,416	8	402		20,946	38	9
10	24	Travel & Seminar	Patient Days	223,416	8	11,946		20,946	1,120	10
11	25	Other Admin. Staff Transport	Patient Days	223,416	8	13,319		20,946	1,249	11
12	26	Insurance-Prop. Liab.Malpractice	Patient Days	223,416	8	16,524		20,946	1,549	12
13	30	Depreciation	Patient Days	223,416	8	54,520		20,946	5,111	13
14	32	Interest	Patient Days	223,416	8	8,774		20,946	823	14
15	34	Rent-Facility & Grounds	Patient Days	223,416	8	23,100		20,946	2,166	15
16	35	Rent-Equipment & Vehicles	Patient Days	223,416	8	16,083		20,946	1,508	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 389,464	$		$ 36,516	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Bank		x	Mortgage	$11,593.59	07/07/99	$ 1,165,000	$ 1,064,919	08/01/05	0.0800	$ 93,313	1
2	Bank of Farmington		x	Van Purchase	$997.95	07/31/01	35,926	30,936	08/30/04	0.0875	856	2
3												3
4												4
5												5
	Working Capital											
6	First Bank		x	Line of Credit	Interest Only	2/1/96	350,000	350,000	01/01/02	0.0700	24,304	6
7	Adkins Commercial Brokerage		x	Commission Note	$167.00	09/10/96	22,500	12,826	08/10/06	0.0900	1,260	7
8												8
9	TOTAL Facility Related				$12,758.54		$ 1,573,426	$ 1,458,681			$ 119,733	9
	B. Non-Facility Related*											
10								Home Office Allocation			823	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 823	14
15	TOTALS (line 9+line14)						$ 1,573,426	$ 1,458,681			$ 120,556	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 28,964	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 29,172	2
3. Under or (over) accrual (line 2 minus line 1).		$ 208	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 29,172	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
Rounding		1	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 29,381	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	27,385	8
	1997	27,195	9
	1998	28,054	10
	1999	28,964	11
	2000	29,172	12

Accrual is equal to 100% of the 2000 Real Estate Tax Bill of $29, 172

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual o taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of ar application for real estate tax exemption unless the building is rented from a for-profit entity**

This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bement Health Care Center COUNTY Piatt

FACILITY IDPH LICENSE NUMBER 0041707

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (217) 678-2191 FAX #: (217) 678-7521

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-00-07-000-609-00	Bement Health Care Center	$ 29,172.00	$ 29,172.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 29,172.00	$ 29,172.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,000 B. General Construction Type: Exterior Block Frame Wood Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc. List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized' [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	109,829	1996	$ 33,600	1
2					2
3	TOTALS	109,829		$ 33,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1996		$ 780,146	$ 20,004	35	$ 22,290	$ 2,286	$ 131,883	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1996	3,650	217	20	183	(34)	1,024	9
10	Parking Lot			1996	1,669	99	20	83	(16)	437	10
11	Driveway			1996	1,050	62	20	53	(9)	292	11
12	Painting and Remodeling			1996	3,155	282	20	158	(124)	869	12
13	Curtains			1996	4,928	440	20	246	(194)	1,373	13
14	Walkway			1996	361	9	20	18	9	102	14
15	Alarm and Fire Equipment			1996	4,437	396	20	222	(174)	1,240	15
16	Sign			1996	434	39	20	22	(17)	146	16
17	Heating and Unit Platform			1996	1,219	109	20	61	(48)	417	17
18	300 Gallon Tank			1997	1,370	35	20	69	34	345	18
19	Install Gas Line			1997	1,861	18	20	93	75	450	19
20	Steel Door			1997	1,170	30	20	59	29	285	20
21	New Gas Line			1997	1,875	48	20	94	46	400	21
22	Gas Water Heater			1997	5,008	128	20	250	122	1,042	22
23	Zone Line Heaters			1997	730	70	20	37	(33)	170	23
24	Zone Line Heaters			1997	754	78	20	38	(40)	165	24
25	Generator Repair			1997	6,112		20	306	306	1,250	25
26	Ase Blacktop			1998	10,062	619	20	503	(116)	1,761	26
27	Electrical Service Generator Work			1998	1,846	47	20	92	45	322	27
28	Zone Line Heaters			1998	716	93	20	36	(57)	126	28
29	Heater			1999	4,956	867	20	248	(619)	620	29
30	Kickplates, Handrails			1999	1,803	46	20	90	44	225	30
31	Grade Driveway and Parking Lot			1999	3,100	265	20	155	(110)	388	31
32	Parking Lot Sealant			1999	1,060	91	20	53	(38)	133	32
33	Garage			2000	8,892	228	20	445	217	667	33
34	Door Frame Protectors			2000	1,059	27	20	53	26	79	34
35	Nine Windows			2000	2,290	59	20	114	55	171	35
36											36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Zone Line Heater	2000	$ 1,312	$ 321	20	$ 66	$ (255)	$ 99	37
38	Carpet	2001	1,297	185	7	93	(92)	93	38
39	Fire system	2001	22,829	317	39	293	(24)	293	39
40	Air System	2001	9,985	117	39	128	11	128	40
41	Fire Door	2001	825	13	39	11	(2)	11	41
42									42
43									43
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 891,961	$ 25,359		$ 26,662	$ 1,303	$ 147,006	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 891,961	$ 25,359		$ 26,662	$ 1,303	$ 147,006	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 891,961	$ 25,359		$ 26,662	$ 1,303	$ 147,006	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 891,961	$ 25,359		$ 26,662	$ 1,303	$ 147,006	1
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 891,961	$ 25,359		$ 26,662	$ 1,303	$ 147,006	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 891,961	$ 25,359		$ 26,662	$ 1,303	$ 147,006	1
2									2
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 891,961	$ 25,359		$ 26,662	$ 1,303	$ 147,006	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 127,302	$ 12,979	$ 12,733	$ (246)	10	$ 68,931	71
72	Current Year Purchases	16,495	2,151	1,378	(773)	10	1,378	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co.			5,111	5,111			74
75	TOTALS	$ 143,797	$ 15,130	$ 19,222	$ 4,092		$ 70,309	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2000 Cadillac	2000	$ 56,099	$ 4,900	$ 11,220	$ 6,320	5	$ 16,830	76
77	Facility Use	95 Dodge Truck	2001	31,500	6,300	3,150	(3,150)	5	3,150	77
78										78
79										79
80	TOTALS			$ 87,599	$ 11,200	$ 14,370	$ 3,170		$ 19,980	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,156,957	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,689	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 60,254	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,565	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 237,295	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Management Company				2,166			6
7	TOTAL				$ 2,166 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,469 Description: Washing Machine-$961; Home Office Allocation-$1,508
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	$	2,358	$ 40,136	$	2,358	$ 40,136	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		129	4,504		129	4,504	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C2-3	hrs		2,515	45,275	232	2,515	45,507	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				18,190		18,190	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	5,002	$ 89,915	$ 18,422	5,002	$ 108,337	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number: Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 48,107	$ 48,107	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable Patients (less allowance None)	308,810	308,810	3
4	Supply Inventory (priced a)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,323	5,323	6
7	Other Prepaid Expenses	6,364	6,364	7
8	Accounts Receivable (owners or related parties	70,000	70,000	8
9	Other(specify)			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 438,604	$ 438,604	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	33,600	33,600	13
14	Buildings, at Historical Cos	900,943	891,961	14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cos	231,396	231,396	16
17	Accumulated Depreciation (book methods	(266,741)	(237,295)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Cost			19
20	Accumulated Amortization Organization & Pre-Operating Cost			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify)			22
23	Other(specify)			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 899,198	$ 919,662	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,337,802	$ 1,358,266	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 203,914	$ 203,914	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposit			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,621	33,621	30
31	Accrued Taxes Payable (excluding real estate taxes			31
32	Accrued Real Estate Taxes(Sch.IX-B	29,172	29,172	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxe	1,375	1,375	35
	Other Current Liabilities(specify):			
36	See Schedule 17A	18,048	18,048	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 286,130	$ 286,130	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	393,762	393,762	39
40	Mortgage Payable	1,064,919	1,064,919	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,458,681	$ 1,458,681	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,744,811	$ 1,744,811	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (407,009)	$ (386,545)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,337,802	$ 1,358,266	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Bement Health Care Center
Provider # 0041707
12/31/2001

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.
C. Other Current Liabilities - Line 36

	Operating	After Consolidation
Accrued Sales Tax	59	59
Accrued Interest	9,662	9,662
Accrued Insurance - General	2,492	2,492
Accrued Insurance - W/C	3,445	3,445
Accrued Expense-Other	2,390	2,390
Total	18,048	18,048

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (222,378)	1
2	Restatements (describe):		2
3	**Prior Period Adjustments**	(47,235)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (269,613)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	235,548	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(372,944)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (137,396)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (407,009)	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,027,400	1
2	Discounts and Allowances for all Levels	(2,220)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,025,180	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,209	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 63,209	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,082	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,082	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	4,081	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,081	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,093,552	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	445,104	31
32	Health Care	748,418	32
33	General Administration	399,376	33
	B. Capital Expense		
34	Ownership	202,635	34
	C. Ancillary Expense		
35	Special Cost Centers	29,621	35
36	Provider Participation Fee	32,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,858,004	40
41	**Income before Income Taxes (line 30 minus line 40)****	235,548	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 235,548	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Bement Health Care Center
Provider # 0041707
12/31/2001

Schedule 19A

XVII. INCOME STATEMENT
Revenue - Line 28

E. Other Revenue (specify):	Amount
Transportation	480
Vending	1,198
Miscellaneous	2,403
	4,081

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	1,993	$ 38,767	$ 19.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,156	5,095	84,810	16.65	3
4	Licensed Practical Nurses	6,080	6,027	81,462	13.52	4
5	Nurse Aides & Orderlies	35,389	35,326	330,082	9.34	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	1,993	16,965	8.51	9
10	Activity Assistants					10
11	Social Service Workers	2,080	1,993	21,870	10.97	11
12	Dietician					12
13	Food Service Supervisor	2,209	2,163	19,971	9.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,694	10,281	77,891	7.58	15
16	Dishwashers					16
17	Maintenance Workers	2,470	2,383	31,546	13.24	17
18	Housekeepers	9,824	9,648	61,220	6.35	18
19	Laundry	4,818	4,785	34,005	7.11	19
20	Administrator	6,324	6,240	114,339	18.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,189	2,190	27,499	12.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coord	1,820	1,733	27,340	15.78	32
33	Other(specify) Transportation	724	627	5,694	9.08	33
34	TOTAL (lines 1 - 33)	93,937	92,477	$ 973,461 *	$ 10.53	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	27	$ 1,119	L1,C3	35
36	Medical Director	Monthly	9,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,300	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	39	1,350	L11, C3	44
45	Social Service Consultant	39	1,100	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	105	$ 13,869		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patti Wright	Administrator	0%	$ 22,670
Angela Edwards	Administrator	0%	15,584
James Petersen	Administrative	60%	53,064
Mark Petersen	Administrative	40%	23,021
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 114,339

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 18,228
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 18,228

C. Professional Services

Vendor/Payee	Type	Amount
Bush & Snyder	Legal	$ 618
Ginoli & Co.	Accounting	3,630
Altschuler, Melvoin & Glasser	Accounting	7,303
ADP	Payroll	6,584
America Online	Computer Services	250
AHCA	Computer Services	425
Mid America Program	Computer Services	1,500
Insight Comm.	Computer Services	58
Charles E. Butzo	Architect	321
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 20,689

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 17,195
Unemployment Compensation Insurance	12,767
FICA Taxes	64,680
Employee Health Insurance	21,004
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	2,412
Employee Relations	7,379
Life Insurance	3,977
Allocated from Management Company	10,692
TOTAL (agree to Schedule V, line 22, col.8)	$ 140,106

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,726
Health Care Worker Background Check	
(Indicate # of checks performed 26)	324
Illinois Health Care Association	3,073
Miscellaneous Dues & Subscriptions	371
Miscellaneous License and Fees	35
Home Office Allocation	268
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,797

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	16,602
Seminar Expense	395
Home Office Allocation	1,120
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,117

* Attach copy of IMRF notifications

**See instructions.

Facility Name	**Bement Health Care Center**
PROVIDER #	**41707**
Period Ending	**12/31/2001**

Schedule 21C

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)			20,689
Home Office Allocation	Computer Services	890	
	Accounting	1811	
	Legal	190	2891
Total (agree to Schedule V, line 19, column 8)			23,580

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9									N/A				
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **No**

(2) Are there any dues to nursing home associations included on the cost repor **Yes**
If YES, give association name and amount **Illinois Health Care Association-$3,073**

(3) Did the nursing home make political contributions or payments to a politic action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at tl end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchase **Yes**
What was the average life used for new equipment added during this period **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expen and the location of this expense on Sch. V. $ **9,131** Line **10**

(7) Have all costs reported on this form been determined using accounting procedur consistent with prior reports? **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangemen **No**
If YES, give effective date of lease **N/A**

(9) Are you presently operating under a sublease agreement ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took ove
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme of Public Aid during this cost report period. **32,850**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? **No** If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed the Department of Public Aid, in addition to the daily rate, been properly classifi in the Ancillary Section of Schedule V **Yes**

(14) Is a portion of the building used for any function other than long term care services f the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, atta a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benef on Schedule V. $ **No** Has any meal income been offset agains related costs? **Yes** Indicate the amount. $ **1,082**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f residents? **Yes** If YES, please indicate the amount of income earned from such program during this reporting period. $ **480**
c. What percent of all travel expense relates to transportation of nurses and patient **0**
d. Have vehicle usage logs been maintained **No**
e. Are all vehicles stored at the nursing home during the night and all oth times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjuste out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this co been attached? **N/A** If no, please explain **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted o out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic performed been attached to this cost report **N/A**
Attach invoices and a summary of services for all architect and appraisal fe

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	97,862	9,062	3,582	110,506	0	110,506	19	110,525
2. Food P	0	93,681	0	93,681	0	93,681	-2,280	91,401
3. Housek	61,220	11,461	0	72,681	0	72,681	0	72,681
4. Laundr	34,005	12,523	152	46,680	0	46,680	0	46,680
5. Heat ar	0	0	52,130	52,130	0	52,130	344	52,474
6. Mainter	31,546	34,266	3,614	69,426	0	69,426	421	69,847
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	224,633	160,993	59,478	445,104	0	445,104	-1,496	443,608
9. Medical	0	0	9,000	9,000	0	9,000	0	9,000
10. Nursin	562,461	42,437	2,342	607,240	0	607,240	0	607,240
10a. Thera	0	232	89,915	90,147	0	90,147	0	90,147
11. Activiti	16,965	392	1,350	18,707	0	18,707	0	18,707
12. Social	21,870	354	1,100	23,324	0	23,324	4	23,328
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	601,296	43,415	103,707	748,418	0	748,418	4	748,422
17. Admin	114,339	0	18,228	132,567	0	132,567	-18,228	114,339
18. Directo	0	0	0	0	0	0	0	0
19. Profes	0	0	20,689	20,689	0	20,689	2,891	23,580
20. Fees,	0	0	5,629	5,629	0	5,629	168	5,797
21. Clerica	33,193	6,517	12,225	51,935	0	51,935	7,954	59,889
22. Emplo	0	0	129,414	129,414	0	129,414	10,692	140,106
23. Inserv	0	0	1,292	1,292	0	1,292	38	1,330
24. Travel	0	0	16,997	16,997	0	16,997	1,120	18,117
25. Other	0	0	3,250	3,250	0	3,250	1,249	4,499
26. Insura	0	0	37,603	37,603	0	37,603	1,549	39,152
27. Other	0	0	0	0	0	0	0	0
28. Total (	147,532	6,517	245,327	399,376	0	399,376	7,433	406,809
29. Total (	973,461	210,925	408,512	1,592,898	0	1,592,898	5,941	1,598,839
30. Depre	0	0	52,390	52,390	0	52,390	7,864	60,254
31. Amorti	0	0	170	170	0	170	0	170
32. Interes	0	0	119,733	119,733	0	119,733	823	120,556
33. Real E	0	0	29,381	29,381	0	29,381	0	29,381
34. Rent -	0	0	0	0	0	0	2,166	2,166
35. Rent -	0	0	961	961	0	961	1,508	2,469
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	202,635	202,635	0	202,635	12,361	214,996
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	18,190	2,146	20,336	0	20,336	-2,146	18,190
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	32,850	32,850	0	32,850	0	32,850
43. Other	0	0	9,285	9,285	0	9,285	-9,285	0
44. Total S	0	18,190	44,281	62,471	0	62,471	-11,431	51,040
45. Grand	973,461	229,115	655,428	1,858,004	0	1,858,004	6,871	1,864,875

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	48,107	48,107
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	308,810	308,810
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	5,323	5,323
7. Other Prepaid Expenses	6,364	6,364
8. Accounts Receivable-Owner/Related Party	70,000	70,000
9. Other (specify):	0	0
10. Total current assets	438,604	438,604
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	33,600	33,600
14. Buildings, at Historical Cost	900,943	891,961
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	231,396	231,396
17. Accumulated Depreciation (book methods)	-266,741	-237,295
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	899,198	919,662
25. Total Assets	1,337,802	1,358,266
CURRENT LIABILITIES		
26. Accounts Payable	203,914	203,914
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	33,621	33,621
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	29,172	29,172
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	1,375	1,375
36. Other Current Liabilities (specify):	18,048	18,048
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	286,130	286,130
LONG TERM LIABILITES		
39.Long-Term Notes Payable	393,762	393,762
40.Mortgage Payable	1,064,919	1,064,919
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,458,681	1,458,681
46.Total Liabilities	1,744,811	1,744,811
47.Total Equity	-407,009	-386,545
48.Total Liabilities and Equity	1,337,802	1,358,266

		Balance per Medicaid Trial Balance
1.	Gross Revenue - All levels of Care	2,027,400
2.	Discounts and Allowances for all Levels	-2,220
	Subtotal - Inpatient Care	2,025,180
4.	Day Care	0
5.	Other Care for Outpatients	0
6.	Therapy	63,209
7.	Oxygen	0
	Subtotal - Anciliary Revenue	63,209
9.	Payments for Education	0
10.	Other Governmental Grants	0
11.	Nurses Aide Training Reimbursements	0
12.	Gift and Coffee Shop	0
13.	Barber and Beauty Care	0
14.	Non-Patient Meals	1,082
15.	Telephone, Television, and Radio	0
16.	Rental of Facility Space	0
17.	Sale of Drugs	0
18.	Sale of Supplies to Non-Patients	0
19.	Laboratory	0
20.	Radiologyand X-Ray	0
21.	Other Medical Services	0
22.	Laundry	0
	Subtotal - Other Operating Revenue	1,082
24.	Contributions	0
25.	Interest and Other Investments Income	0
	Subtotal - Non-Operating Revenue	-
27.	Other Revenue (specify):	4,081
28.	Other Revenue (specify):	0
	Subtotal - Other Revenue	4,081
30.	Total Revenue	2,093,552
31.	General Services	445,104
32.	Health Care	748,418
33.	General Administration	399,376
34.	Ownership	202,635
35.	Special Cost Centers	29,621
35.	Provider Participation Fee	32,850
37.	Other	0
40.	Total Expenses	1,858,004
41.	Income Before Income Taxes	235,548
42.	Income Taxes	0
43.	Net Income or Loss for the Year	235,548

Page

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Bement Health Care Cen** **02:05 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	6,871	equal to	6,871	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	120,556	equal to	120,556	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	29,381	equal to	29,381	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	170	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	60,254	equal to	60,254	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	2,166	equal to	2,166	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,469	equal to	2,469	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	90,147	equal to	90,147	0	O.K.	Pg16 Z12+Z14.	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	18,422	equal to	18,422	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	445,104	equal to	445,104	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	748,418	equal to	748,418	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	399,376	equal to	399,376	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	202,635	equal to	202,635	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	29,621	equal to	29,621	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	32,850	equal to	32,850	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	535,121	equal to	562,461	-27,340	FAILED	Pg20 K11..K15	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	16,965	equal to	16,965	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	21,870	equal to	21,870	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	97,862	equal to	97,862	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	31,546	equal to	31,546	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	61,220	equal to	61,220	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	34,005	equal to	34,005	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	114,339	equal to	114,339	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	27,499	equal to	33,193	-5,694	FAILED	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	973,461	equal to	973,461	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,119	< or = to	3,582	-2,463	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	9,000	< or = to	9,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,300	< or = to	2,342	-1,042	O.K.	Pg20 X14..X16	B. & C.	I7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,350	< or = to	1,350	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,100	< or = to	1,100	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	114,339	equal to	114,339	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	18,228	equal to	18,228	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	20,689	equal to	20,689	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	140,106	equal to	140,106	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,797	equal to	5,797	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	18,117	equal to	18,117	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	32,850	equal to	32,850	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	No	< or = to	10,692	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	No	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,375	equal to	1,408	-33	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	18,288	equal to	18,288	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	1,458,681	equal to	1,458,681	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	29,172	equal to	29,172	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	33,600	equal to	33,600	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	891,961	equal to	891,961	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	231,396	equal to	231,396	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	237,295	equal to	237,295	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-407,009	equal to	-407,009	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	235,548	equal to	235,548	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,337,802	equal to	1,337,802	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1